Culturally-Shaped Linguistic Themes of Doctor-Patient Encounters in Mosuli Arabic: A Conversation Analysis

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Abstract

While the main defining linguistic characters of the medical consultation are relatively shared around the world, there are some culturally specific themes within different societies. Through conversation analysis, we studied the routines of seventy five doctor-patient encounters in order to shed light on some of the peculiar linguistic features of Mosuli Arabic observed throughout various stages of the medical consultation from opening up to closure. Such features include certain unique conversational strategies that are used to shape various social actions during the course of the medical encounter, such as expression of empathy, recognition of "doctorability" of patient's illness, and establishing rapport and collaboration between doctors and patients. The study adopted Heritage's (2004) analytical model, to probe the six defining features representing the "institutionality" of doctor-patient encounters, attempting to answer the question whether there are any peculiar linguistic patterns of communication during doctor-patient encounters in Mosuli Arabic. The study hypothesizes that although doctor-patient encounters seem to be an extremely organized social activity, there must be some peculiar local linguistic defining features within the local Mosuli Arabic community. Our findings have shown that Mosuli Arabic is in fact rich in unique linguistic

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resources, in form of lexical and syntactic choices in particular, that can be usefully employed during doctor-patient communication.

Keywords: Medical communication, Conversation analysis, Mosuli Arabic.

1. Introduction

Effective communication between doctors and patients plays a significant role in achieving a trusting interactional rapport where a patient's trust in the physician is one of the principal correlates to important outcomes of the medical care, including adherence to doctor's advice, patient satisfaction, and improved health status. (Safran, et al., 1998:213). However, medical care has become increasingly complicated and fragmented, and the traditional warm, long term relationship with a single doctor has become quite rare indeed (Chang, et al., 2013:24). Therefore, there is an increasing need for communication that effectively achieves proper information exchange and negotiation of mutual expectations between doctors and patients, which would eventually reassure patients and increase their adherence to various treatments (Stewart, et al., 1999:25).

Focusing on patient-oriented communication skills has been explored within medical education which is necessary to yield effective medical practitioners (Levinson and Roter, 1993:318; Roter, et al., 1995:1877; Roter et al., 1998:181). In addition to medical education, non-physician academics such as sociolinguists – who are interested in how social issues or values could affect doctor-patient interaction – have also been concerned with the subject of medical communication (Von Raffler-Engel, 1989). Furthermore, investigators have explored some concerns with health care in multiethnic societies (Qureshi, 1989), in addition to the doctor-patient interaction in one culture (Von Raffler-Engel, 1989) and have also conducted comparative studies on communication in general where such research has shown that communication difficulties already arise due to differences in the medical subculture of the doctor, and illness subculture of the patient (Stein, 1990).

Given the growing cultural diversity among doctors and patients, and the resulting necessity for effective intercultural

communication between doctors and patients, research is virtually needed in connection with the degree to which patterns of doctor-patient communication vary between various cultures (Ohtaki, et al., 2003:277).

However, little is known about this issue within local Iraqi, let alone Mosuli society.

2. Review of Relevant Literature

Research on doctor-patient encounter has revealed that it is dominated by a form of highly structured and predictable routines. Such routines manage how information is obtained from the patient throughout various phases of the consultation, and how the patient is expected to behave and respond at each relevant subcomponent of the medical encounter (Have, 1989:118; Heritage, 2010:61).

There are divergent expectations of doctor and patients while they approach the consultation in relation to the content and organization of discourse. Such divergent expectations originate from diverse knowledge systems, perceived rights to access to such systems, and in their different means of viewing and conceptualizing illness, which reflect a form of tensions between the "voice of medicine" and the "voice of the lifeworld" (Mishler, 1984:14). Such tensions could lead to interactional dilemmas for the interlocutors (Gill and Maynard, 2006:116).

For the most part of the encounter, patients remain cooperative in maintaining the structure of the medical encounter (Gill and Maynard, 2006:115), as these routines can help in minimizing the risk of conflict or confrontation between doctors and patient, because much of the structure of the consultation centers around the use of questions by the doctor (Raymond, 2003:940). Such questions set a specific agenda, and enable the doctor to maintain a form of control over multiple dimensions within the encounter including topic initiation and sequencing (Barry, et al., 2001:487), the kind of knowledge admissible by the patient (Drew 1991:21), and the expression of ideas and feelings (Have, 2001:251). In this way asymmetry between doctors and patients is reinforced.

In the same vein, restrictions imposed by doctors' questions can make it difficult for patients to determine how and when to

voice their own anxieties, and to get issues on the table without disrupting the doctor's information gathering process. Doctors, on the other side, must determine how to react to such attempts before their data gathering process is complete (Gill, et al., 2001:55; Gill and Maynard, 2006:150). One aspect of medical questioning is recipient design, whereby the phrasing of the standard array of questions is accommodated to the specific patient based on the collected information from previous questions (Raymond, 2003: 940; Heritage, 2010:47), and such recipient design could contribute to building rapport between doctor and patient.

The universalistic nature of medical education implies that the management of consultations should transfer across national cultural boundaries, and that the voice and language of medicine represent a type of "professional lingua franca" so to speak, which neutralizes any cultural impact. Medical educators have made an assumption that multicultural competence is found externally from oneself, and thus they distanced themselves and at the same time preserved the universal and neutral values so carefully attended to in their medical training. (Martin, 2015:5). There are different culturally based assumptions about distribution of control, and doctors' or patients' roles, which could be reflected on the medical consultation (Erickson and Rittenberg, 1987:413). For example the foreign medical graduate who only recently has begun to practice medicine in the United States through a residency training program, attempts to conduct interaction with patients using a non-U.S. cultural frame for role relations. He or she then uses conversation and discourse strategies that differ from those normally expected by American patients (ibid). Such observations shed light on the importance of studying the unique and defining linguistic norms of doctor-patient encounters within a specific culture, in order to describe and document the relevant culturally shaped linguistic conversational strategies of this social conduct, which would not only help in understanding the variations between different cultures, but also could be quite valuable as a baseline for any relevant cross cultural linguistic analysis.

According to Stein (1990:xiii) there are informal, largely unconscious models that influence medicine, such models consist of

a subject matter that, although considered and acted upon in medical education, is rarely formalized in literature of medicine which is not merely an assembly of doctors and nurses, medical specialties, and institutions, but also is a cultural system in its own right, with an internal coherence based on a system of core values, metaphors, beliefs, attitudes, and linguistic themes, that in turn are influenced by a deeper, largely unconscious, cultural core. It is against such a view that we intend to linguistically examine doctor-patient encounter in Mosuli Arabic.

3. Methodology

The research was approved by the ethical committee of Nineveh Health Directorate which is the highest local governmental authority regulating all categories of research within the medical field. Data collection was carried out by recording medical encounters which were suitable to be included in our study, namely conversation in Mosuli Arabic, in an appropriate quiet environment, and with absence of any obstacles to the proper stream of interaction between doctors and patients. Seven doctors agreed to participate in our study which was carried out in Mosul city in Iraq during the period of three months, January-April, 2021, and a total of seventy five recorded doctor-patient encounters were obtained. Transcription was performed by two-line representation of data, the first line with an IPA representation of the original Mosuli Arabic speech, and the second line was an idiomatic English translation. All identities, names, personal details, and other related issues were obviously kept totally anonymous in agreement with ethical standards. The study adopted Heritage's (2004:225) analytical model. On the other hand the analytical procedure was according to the description of Have (2007:122-124). Extracts which include examples taken from different encounters are labeled with an asterisk (*).

4. Data Analysis and Discussion:

Going through the data we could clearly observe that doctor-patient encounter was composed of highly organized constituents, including six distinctive phases: an opening, discovering the reason for the consultation, verbal and physical examination, consideration of the condition of the patient, treatment, and finally closure of the

encounter. Findings will be presented according to the main relevant (culturally-related) linguistic milestones, within the conversational stream.

4.1 The initial opening:

This represents the phase of relating to the patient and establishing primary connection or rapport, for example:

Extract 1- [Kassab-Bashi, R.: MAT: 2021]

1	Patient:	/ʔassalæːmʊ ʕaleɪkʊm/
		Peace be upon you
2	Doctor:	/wa ʕaleɪkʊm ɪssalæːm/
		Peace be upon you
3		/ja ʔahlan wasahlan/
		You are most welcome =
4		/ʔstariːħ/
		= have a seat
5		/halawmarħaba/
		Welcome
6		/ʔaʃʃɔːnak/
		How are you
7	Patient:	/ʔalħamdulilla/
		Thanks God Alhamdulillah
8	Doctor:	/jɑ halawmarħaba/
		Welcome

Here, it is worth noticing that the initial questions of the doctor were part of what can be called as "how are you sequences" since such adjacency pairs of questions-answers were responded to by the patient as initial greetings rather than being actual solicitation of the patient's complaints. Theses sequences were sometimes repetitive in nature going back and forth in accordance with local cultural customs, as such reverberation, so to speak, could express some form of warmth or hospitality within the setting. Besides, these greetings and replies involved some religious invocations like /ʔalħamdulilla/ meaning (thanks to God), which were extremely

common within our data pool. Such religious invocations are clearly in line with local cultural norms.

4.2 Discovering the main reason for the consultation of the patient

This was achieved by initiating a new sequence by the doctor in a form of brief question for example:

Extract 2- [Kassab-Bashi, R.: MAT: 2021]

1	Doctor:	/salæːmæːt/
		Salamaat
2		/ʔaʃ tiʃki: (?)/
		What do you complain of?
3		/ʔaʃ qajjɪwʤaʕak (?)/
		Where do you feel a pain?

Here, we could note that this phase had two significant phenomena:

(1) The initial linguistic approach of the doctor could involve three social actions achieved simultaneously at the very same time. The first one is soliciting the patient's concerns which is quite natural in this phase, yet the second action seems to involve an element or expression of empathy by using such local lexical choice as /salæːmæːt/ which has an extended spectrum of multiple meanings like "I hope you are fine" or "wish you a speedy recovery" or "it's ok!" which shows that the physician is really concerned about the patient, rather than merely wanting to gain specific technical (biomedical) information about a physical complaint.

Furthermore, the usage of such expression as /salæːmæːt/ seems to imply some degree of recognition by the doctor of what has been referred to by Heritage and Robinson (2006:57) as the "doctorability" of patient's problem. Thus in comparison with a form of neutral question in which we find in western literature as for example, "how can I help you?", or "what do you complain of?", where sometimes the patient might be at pains trying to show that his or her condition is really "doctorable" in the aforementioned

sense, that is to say, to show that there is certain complaint which is really worthy of some medical attention (although it is not necessary that the doctor was not recognizing this matter). Here, in our data, it is clear that this issue can be distinctively resolved from the commencement of the medical encounter, where the doctor recognizes the concept of "doctorability" from the very beginning of conversational interaction with the patient, and thus will save the time and effort for the patient by relying on a single worded utterance as /salæːmæːt/ which will indirectly imply that: I know you are sick, I am sympathizing with you, and I am here to help. Such strategy seems to be peculiar to Mosuli (or Iraqi) Arabic as there is no equivalent English expression which could be used, or relied upon to involve such a unique combination of conversational social actions. In fact, it seems very odd and strange that someone could achieve such a wide and variable range of different social actions using merely one single word! Yet it seems that this could be explained by the rich sociocultural and historical heritage of Mosuli Arabic.

(2) Another phenomenon is that while the patient is just entering the physician's room, if there was a visually obvious feature as for example a patient holding an x-ray film, or a visually noticeable disability, (like limping or difficulty in walking), then these issues will be most likely utilized to initiate the second phase of the encounter, rather than the classical aforementioned questions. Again this could also imply an empathic content within the second phase of the encounter.

*** Extract 3- [Kassab-Bashi, R.: MAT: 2021]**

1 Doctor: /salæːmæːt ʔaɣʃaʕ ʃajjɪl ʔaʃɪʕʕɑ/
Salamat I see that you are holding an x-ray
2 /salæːmæːt ʔɪndak wadʒaʕ bdˤahɣak (?)/
Salamat, do you have pain at your lower back?

4.3 Performing verbal and physical examination:

Verbal examination is composed of a series of sequences involving short question-answer adjacency pairs. Here, we could observe multiple characteristic phenomena:

(1) Such series of sequences are very commonly composed of relatively short turns with very few turn construction units (TCU), for example:

Extract 4- [Kassab-Bashi, R.: MAT: 2021]

1	Patient:	/dˤahɣj: juːdʒaʕniː/ My back hurts
2	Doctor:	/weːn ʔlwadʒaʕ (?)/ Where is the pain?
3		/bljamiːn ʔllaː jasæːɣ (?)/ Is it in the right or left?
4	Patient:	/bildʒihteːn/ Both sides
5	Doctor:	/jinzal ʔala ɣiʒleːk (?)/ Dose it go to your feet?
6	Patient:	/læː/ No

Here, we notice that nearly all of these sequences and adjacency pairs are initiated almost exclusively by the doctor, who seems to decide when the next topic is initiated, and whether the investigation of the current topic was satisfactory or not. This empirical observation seems to support what was raised by Mishler, et al. (1989:326) in that there is a degree of control on the medical encounter from the side of the doctor. Also, it is worth noting that the overwhelming majority of these adjacency pairs are in fact close ended questions, where the patient is expected to provide specific answers in the form of yes or no replies, or to select one answer from multiple specific (but limited) choices. Such closed ended questions (as opposed to open ended questions) will clearly limit the patient's ability to provide a more detailed account of the illness in his or her own words.

(2) There is some degree of overlapping speech between the doctor and patient, where the doctor seems to expect the timing of the end of patient's TCU, and starts his next question before the patient actually arrives at the transition relevance place TRP. This could be explained by the accumulative experience from the side of the doctor where he or she tries to save the time and effort to both patient and doctor alike, but also could have some element of sociocultural norms where such an overlap is also common in ordinary conversation.

Extract 5- [Kassab-Bashi, R.: MAT: 2021]

1 Patient: /kæ:n ʕndi: ʔnzilæ:q ɣadˤru:fi: bdˤahɣi:/
I had a prolapsed [disk at my back]
2 Doctor: /hassa ħalijjan/
[Now at this time]
3 Patient: /wkæ:n ʕndi: dˤaytˤ ʕalʕasˤab/
And I had pressure [on the nerve]
4 Doctor: /ʔe: ʔe:/
[Yes Yes]
5 Patient /ʔalħamdlilla ʔtħassantu/
Thanks God it [improved
6 Doctor: /ʔe: χɔ:ʃ/
[Yes that's ok]

(3) There were some remarkable incidences of interruption of the patient from the side of the doctor, where the later could initiate a new question in the middle of patient's TCU, as for example:

Extract 6- [Kassab-Bashi, R.: MAT: 2021]

1 Patent: /dˤahɣi ju:ʤaʕni: kæ:n/
My back hurts [it was
2 Doctor: /waʤaʕ binnisˤ/
[Is pain in the middle=
3 =ʔllæ ʕalæ ʤiha/
=Or on a side]

4.4 Storytelling strategies:

As it has been identified earlier, doctor-patient encounter is based on a very long sequences of adjacency pairs, composed of questions and answers where the doctor self-selects his or her turn, and the patient being almost always selected by the doctor, and during these sequences the doctor adopts a position of lack of knowledge, which changes into knowing after conclusion of the specific sequence, after which, a new sequence will be initiated by the doctor. Yet, this pattern seems to shift when the patient adopts a position of a story telling where we could notice that:

(A) There are multiple turns from the side of the patient.

(B) For each turn the doctor responds sparingly, usually with a minimal token.

(C) There are minimal incidents of interruption or overlaps from the side of the doctor.

We could recognize three different strategies where the patient could adopt the identity of a story teller, and thus changing the dynamics of the conversation:

(A) Projecting actions or events to a substantially far point in the past, for example:

Extract 7- [Kassab-Bashi, R.: MAT: 2021]

1	Doctor:	/weːsˁab ʔisˁiːɣ ʕdkiː ʔlwadʒaʕ(ʔ)/
		Where do you feel the pain?
2	Patient:	/bɣkbtiː/
		In my knee
		/ʔawwal mæːbadæː qabl χams sniːn/
		It started five years ago
3	Doctor:	/baleː/
		Yes
4	Patient:	/ʔawwal mæː ʃaʕartu blwadʒaʕ/
		When I first felt the pain
5		/bhaðæːk ʔlwaqt ʃltu ħæːdʒiː ħaqiliː/
		At that time I was lifting a heavy object
6		/ʃaʕartu ʕbæːlak/

I felt that something as if
7 /ʃeː ʕabæːlak tˁaq/
Was a kind of tearing
8 /faɣħtu ʕaldktɔːr/
I went to a doctor
9 /wuʕatˁaːniː/
And he gave me ……

Here, we could notice that the patient continued to talk as far as the events were continuously projected into the past, but once the description of such events reaches the present illness, there will be an abrupt shift where the encounter returns to its usual form of short TCU with multiple incidents of overlap and interruption as it has been described earlier.

(B) The second strategy is describing the current events within the very near past in an interesting mode of a series of questions in a "rhetorical strategy" which is adopted by the patient, rather than the normal affirmative statements as it is usually expected, as for example:

Extract 8- [Kassab-Bashi, R.: MAT: 2021]

1 Doctor: /bʔaj makæːn ʔakuː waʤaʕ(?)/
Where do you feel the pain?
2 Patient: /ʔaʃʕr biːnuː bktfiː/
I feel it in my shoulder
3 /ʔaʃsˁæːɣ bktfiː dktɔːr(?)/
What happened to my shoulder doctor?
4 /kntu qadaɣsl ħwas ðqæːl/
I was washing heavy clothes
5 /faʔaʃsˁæːɣ baʕdæː(?)/
What happened next?
6 /mæː baʕd ʔatˁiːq ʔaħarrkuː/
I felt a difficulty to move it
7 /faqmtu ʔaʃʕmltuː(?)/
And what happened next?
8 Doctor: /baleː/

Yes

9 Patient: /ʔaχaðtu dawæ:/
I took a medication

These related series of questions seems to shift the patient's identity into a position of a storytelling, where the doctor will adopt a position of a recipient, and such position is associated with minimal incidents of interruption. This strategy of narrating events in such a question-answer dynamics, where the narrator asks and replies him- or herself at the same time, seems to be an adaptation of local sociocultural conversational linguistic norms into the medical encounter.

(C) A frank and direct request from the side of the patient, where the patient frankly asks the doctor to listen to his story from the beginning, for example:

Extract 9- [Kassab-Bashi, R.: MAT: 2021]

1 Doctor: /ʔaʃʕndak(?)/
What do you complain of?
2 Patient: /ɣæ:ħ ʔaħke:lak ʔʃʃaɣlæ: mnlʔawwal/
I will tell you everything from the beginning
3 /ħatta/
So that
4 /tʕɣf klʃe: ʕan ʃaɣlti:/
You could know everything about my condition

This request in a direct and frank approach was not uncommon within our pool of data, which again probably has some element of sociocultural causes where the patient usually although usually avoids such a direct strategy, yet the conversational conduct could go in line with local norms concerning what is expected from the doctor in duty.

4.5 Termination of the medical consultation:

It is usually hinted by the physician when he or she gives the patient an appointment to the next follow up visit, as for example:

Extract 10- [Kassab-Bashi, R.: MAT: 2021]

1 Doctor: /waʔaɣiːd ʔaɣʃaʕki sbɔːʕʤʤajji/
I want to see you next week
2 Patient: /ʔinʃæːɬa/
Inshallah

Final conclusion is achieved by the patient thanking the doctor, and the reciprocal expression of empathy by the later, for example:

Extract 11- [Kassab-Bashi, R.: MAT: 2021]

1 Patient: /ʃukran ʤaziːlan dktɔːr/
Thank you very much doctor
2 Doctor: /jæː ʔahlan wasahlan/
You are most welcomed
3 /Salæːmæːt ʔlʕæːfja ʕndak/
Salamat hope you get well

Here, again we could observe the same lexical choice /salæːmæːt/ which was used within at the beginning of the encounter, is being used at the termination, albeit this time with a mining towards something like “hope you get well soon” which is an implication of empathy by the doctor.

Yet, we could sometimes observe that even after this final phase it is common to find the patient asking a question which seems to imply an obvious answer from the side of the physician as for example:

Extract 12- [Kassab-Bashi, R.: MAT: 2021]

1 Patent: /dktɔːr/
Doctor
2 /jaʕniː maʔidˤalbæːliː/
You mean that I should not worry?

3 Doctor: /læ: læ: sahli: haj/
No no it is a simple issue

Such scenario seems to be a repetition of a matter which has already been clarified and discussed, yet it comes after the expected termination of the encounter. Contrary to what has been described in western literature of what is referred to as "by the way syndrome" (West, 2006:380) where the patient initiates a completely new medical issue or question at the conclusion of the visit, here in our study we observed that there is a clear difference that there is no new or unrelated medical issues, but a mere repetition of the same initial problem which has already been discussed during the encounter.

4.6 Overall structural organization

There were few examples of tension between doctors and patients as to the boundaries of each specific stage of the consultation, and whether both sides agree upon the final conclusion of certain activity. In the following example, the doctor wants to shift from the stage of verbal examination into the next step of physical examination which is faced by frank rejection by the patient:

Extract 13- [Kassab-Bashi, R.: MAT: 2021]

1 Doctor: /ʔstariːħ ʕassariːr balæ: zaħmiː/
Sit on the couch please
2 Patient: /dχalli: ʔakamml ʔlqssa/
Let me finish my STORY
3 /ʔaʃsˁaːɣliː/
About what happened to me

These incidents reflect that the patient is committed to an identity of a story teller, and subsequently the doctor agrees to listen in accordance with a direct request from the patient. Such dynamic change is characteristic feature reflecting the institutionality of the

encounter. Also, these incidents of tension between doctor and patients were sometimes at the shift towards treatment phase, where the patient might want to continue to discuss the diagnosis before shifting to treatment, while the doctor want to go ahead with the stream of the encounter. Within this tension, we could observe incidents of interruption of the doctor by the patient in order to keep the encounter within the current phase. Such interruptions were sometimes associated with the use of doctor's name to attract his or her attention as for example

Extract 14- [Kassab-Bashi, R.: MAT: 2021]

1 Doctor: /hæːðæː jsammɔːnuː ʔiltihæːb ʔaʕsæːb/
This is called neuropathy
2 Patient: /mn ʔaqʕd dktɔːr/
[When I sit down doctor (name)]
3 Doctor: [fa bnnsba]
[So for the]
4 Patient: /mn ʔaqʕd dktɔːr/
[When I sit doctor (name)]

Here, we could notice that while the incidents of interruption were mainly initiated by the doctor at the initial phases of the encounter, yet at the final stages, the pattern of interruption is somewhat reversed where the patient is mainly interrupting the doctor which reflects some degree of mismatch between a patient wishing for more thorough discussion of his or her complaint, and the doctor who seems to be satisfied with the diagnosis and wishes to go ahead in the conversation to the stage of treatment. Yet, in all of these incidents the doctor's response was affirmative, and seems to go with the same initial plan or line of diagnosis and treatment, thus, apart from showing sympathy to patient's complaints, none of such incidents of interruption by the patient had any major effect on the expected flow of conversation, which show that probably once the doctor was satisfied about certain decision, and had specific treatment plan in mind, there might be minimal effect of any conversational strategy which will be adopted later on by the patient.

4.7 Turn design

Going through our data pool, we could specify few incidents where turns are being designed to achieve certain purpose. For example, on the side of the patient, we could find some turns where the patient describes his or her symptoms in way which give indirect implication about what Mishler (1984) referred to as "lifeworld" issues, as for example:

Extract 15- [Kassab-Bashi, R.: MAT: 2021]

1	Doctor:	/hæːj ʔaʃqad sˁæːɣla ɣkbtki tuːʤaʕaki(?)/
		For how long did you feel pain in your knee?
2	Patient:	/hæːj sˁæːɣla sniːn ʕalæː hæːj ʔlħala/
		I've been with this for many years
3		/tziːd maʕa ʃɣllbeːt/
		It increases with house work
4		/mn ʔanadˁdˁf kl jɔːm/
		When I do my daily cleaning
5		/mn ʔadangr ʔaʃtɣl/
		When I kneel at work
6	Doctor:	/ʔibajjn kðiːɣ ʃɣl beːt ʕdki(?)/
		Seems you [have a lot of work?
7	Patient:	/ʔeː ʔeː/
		[Yes yes]
8		/kl banæːti mzawwaʤiːn/
		All my daughters are married
9		/ʔiːdiː ʔbbaħdiː blbeːt/
		I'm alone in the house
10		/kllu: ʔʃʃɣl ʕalajjiː/
		All work duty is on me

Here, we could notice that the patient is giving an indirect implication that she is having difficult times at her household environment, which could be directed towards targeting a third accompanying person, (a patient's chaperon, for example a husband, or a mother in law), where such turn design serves not only to

describe the bodily physical issues, but also other related social factors. It is worth noting that within local cultural norms, all female patients (and a substantial portion of males as well) are accompanied with a chaperon in line with the local sociocultural norms. A reciprocating strategy can be adopted by the doctor in order to accommodate to this turn design by giving advice about physical "biomedical" issues, and another social action could involve showing empathy towards patient's "lifeworld" suffering, for example:

Extract 16- [Kassab-Bashi, R.: MAT: 2021]

1	Doctor:	/tħtæːʤiːn ræːħa/
		You need some rest
2	Patient:	/ʔeː/
		Yes
1	Doctor:	/ʔibajjn qattʃtɣliːn ʔakðaɣ mn lajæːqtki/
		It seems that you are taking effort more than you can
4	Patient:	/ʔeː wałła/
		Yes
5	Doctor:	/jnɣæːdlki ʔaħħad ʔisæːʕdki/
		You need someone to help you

Contrary to Mishler's (1984:14) classic argument, we could find substantial amount of turn design to include patient's "lifeworld" issues, where doctors could intentionally design their turns to address these personal matters. Such difference can again be explained by sociocultural discrepancy between western culture and our local Mosuli culture, where it seems that addressing "lifeworld" side of patient's complaints represents an essential part of doctor-patient encounter in Mosuli Arabic.

4.8 Lexical choices:

One of the very common and quite characteristic lexical feature was that doctors continuously prefer the use of the personal pronoun "we" rather than "I" while explaining medical issues to the patient, for example:

Extract 17- [Kassab-Bashi, R.: MAT: 2021]

1 Doctor: /hæːðæ: nsammiːnuː sawafæːn ɣeːr mstaqr/
We call this an unstable osteoarthritis
2 /ħælijjan mæː tħtæːʤ ʔbɣa mawdˁʔijja/
We don't usually use a local injection
3 /ʔħnæː ʕadatan ntˁlb faħsˁ raniːn ħattæː nɣʃaʕ hæːj ʔlʔmuːr/
We usually request an MRI to evaluate such condition

This usage of "we" rather than "I" reflects a high degree of institutionality of the medical encounter where the doctor takes the identity of a member of a higher institutional group where a specific standards are followed and implemented by such a higher organization. Also, such lexical choice clearly increases the degree of authority and control from the side of the physician.

Contrary to Mishler et, al.'s (1989:333) position, where they argue that the use of such pronoun is a form of royal or bureaucratic expression of doctor's authority, here at our local Mosuli data pool it is evident beyond any doubt that such a first person pronoun as 'we" clearly indicates collaboration and concern by the doctor as it is attested by the use of the same pronoun by the patient, for example:

Extract 18- [Kassab-Bashi, R.: MAT: 2021]

1 Doctor: /ʔaʃqad sˁæːɣlnæː ʕalʕilæːʤ(?)/
For how long we've been on medication?
2 Patient: /sˁæːɣlnæː ʃahɣ wnsˁ/
For one and a half month
3 Doctor: /bwaqtæː ɣajjarnæː ʕalθmæːniːn/
We can change the dose to 80
4 /ʔabulʔarbaʕiːn χlsˁ(?)/
Is the drug of 40 finished by now?

5 Patient: /waqqafnæːnu: qabl mæ: jχlasˁ/
We stopped it before it was finished
6 /waraʤaʕnæ: ʕala ʔawwal dawa/
And then we returned to the first drug

Here, we can clearly notice that the patient while describing dose reduction, he uses the reference "we stopped it" which is conclusive evidence that the context here is actual collaboration between doctor and patient who are working "together", rather than a one-sided royal or bureaucratic social action by the doctor as Mishler, et, al. (1989) argues. The explanation is clearly sociocultural, which shows that there is in fact a local linguistic peculiarity of Mosuli Arabic which is not necessarily matching with all western sociocultural linguistic norms.

But in some incidents, we could observe that this pattern of using "we" is changed to third person "they", as for example:

*** Extract 19- [Kassab-Bashi, R.: MAT: 2021]**

1 Doctor: /hæːðæ: jsammɔːnu: watar waħʃiː/
They call it the lateral ligament
2 /hæːðæ: ʔddawæ: batˁtˁalu jstaχdmuːnuː/
They don't use this drug anymore

Such an appeal to a third person reference seems to be peculiar to our study, as according to our best knowledge we could not find any equivalent or similar position within published western literature. Here, we would argue that such a unique phenomenon can be explained according to some local deeply rooted sociocultural native acknowledgement that most of the medical (or scientific) knowledge is in fact drown from western or foreign sources, and thus an appeal to the personal pronoun "they" could imply a much wider (and probably more solid) position of institutionality, in which the doctor needs to rely upon to solidify his or her position whenever a difficulty is being faced to confront (or change) patient's stance towards certain medical issues.

Another lexical observation was the use of certain peculiar phrases during requests by the doctor, for example:

Extract 20- [Kassab-Bashi, R.: MAT: 2021]

1	/ʔqʕdli ʕassariːr/
	Sit on the couch for me
2	/χðli: hæːðæ: ʔddawæː/
	Take this drug for me
3	/ʔʕmalli: hæːðæ: ʔttamriːn/
	Make this exercise for me

Here, the use of such action as "for me" seems odd in comparison to the norms of a usual conversation, where one would normally expect a usual request form (sit on the couch, take this drug, ….etc.). Such unusual method of requests seems to contain two actions at the very same time namely, the request itself which is quite normal, but also an approach or strategy to express empathy and concern from the part of the doctor. In such strategy, he or she is showing that as if the patient is doing a favor to the doctor by following an advice or taking a medication, where in fact the benefit is related to the patient, who is the party which is asking for help. Therefore, in such a lexical choice the doctor is expressing a direct involvement and interest in patient's health and wellbeing. Again, this observation seems to be quite unique to our study, which can be considered a peculiar feature of Mosuli Arabic as there is no functional linguistic equivalent to such expression within English language.

In relation to this subject, we could also observe a nearly fixed pattern of addressing patients by the doctor which is clearly gender related, where the male doctor almost always addresses a female patient as "my sister", in contrast to a male patient where very rarely addressed as "my brother", for example:

Extract 21- [Kassab-Bashi, R.: MAT: 2021]

1 Doctor: /halæː ʔχtiː/

Welcome my sister

2 /ʔtfadˤdˤali: ʔχti:/

Go ahead my sister

This is obviously related to local sociocultural norms of addressing people within local society, where such title will clearly imply a high standard of care and professionalism from the side of the doctor. Such position is sometimes reciprocated by senior female patients, where the commonly address a younger male doctor as "my son". Such use seems to be quite common when the patient is describing what she considers as somewhat embarrassing description of a complaint which is not discussed with a male person according to the local social norms. Here the use of "you are my son" or "you are also my son" will precede the specific description of the physical complaint, for example:

Extract 22- [Kassab-Bashi, R.: MAT: 2021]

1 Patient: /ʔnta ham ʔbni:/

You are also my son

4.9 Interactional asymmetries / Epistemological caution and asymmetries of knowledge

In fact, during the analysis of our pool of data, we could observe mixed results concerning this specific issue. While we could pinpoint some incidents of "epistemological caution" from the side of the doctor, yet it should be admitted that this epistemological caution was not the norm or routine of the medical encounter in Mosuli Arabic, where it seems that most of its general theme reflects a quite assertive language on the part of the doctor, for example:

Extract 23- [Kassab-Bashi, R.: MAT: 2021]

1 Doctor: /ʕdki: sawafæ:n ɣe:r mstaqr blɣkbi:/

You have an unstable osteoarthritis of the knee

2 /hæ:ðæ: ʔħnæ: nsammi:nu: daraʤa ðanija/

This we call it second degree
3 /ʔlʔaʃiʕʕa tˁabiʕijjiː/
The x ray is normal

This does not mean that there was no linguistic evidence of some degree of epistemological caution within doctor-patient encounter, as we could pinpoint few incidents, for example:

Extract 24- [Kassab-Bashi, R.: MAT: 2021]

1 Doctor: /ʔinʃaɬɬa/
Inshallah
2 /ʔatwaqqaʕ ɣaħ titħassan/
I expect that you will improve
3 /ʔlfaħsˁ ʔibajjin tˁabiːʕiː/
The laboratory report seems normal
4 /ʔrraniːn ʔibajjin tˁabiːʕiː/
The MRI seems good
5 /ʕala hæːðæː ʔlfaħsˁ/
According to this test

Here, we can clearly observe that the doctor is using a form of non-assertive language (for example “it seems”, “according to this test” …etc.) where the doctor is cautious not to take a full straightforward position concerning some issues within the medical encounter. We also clearly noticed that this caution is more common during the phases involving discussing the diagnosis (and assessing the prognosis), or outcome of a certain specific treatment, while on the other hand such epistemological caution was almost completely lacking during the phase of verbal and physical examination.

Here, an empirically sound explanation of such phenomena would probably need a survey or an interview with doctors and patients which is clearly outside the scope of our study, yet one cannot escape the temptation of putting some intuition or best guess to explain this pattern of epistemological cautions. Thus, we could reasonably argue that this can be related to certain sociocultural difference between Mosuli society and western culture, where we

think that within Mosuli local culture, a doctor who appeals to a lot of epistemological cautiousness can be viewed as inefficient by patients, or as being lacking the proper knowledge or experience. This could explain why doctors avoid such linguistic caution during the stage of physical examination which directly reflects their personal medical skills, while on the other hand they could be sparingly cautions while discussing laboratory investigations or a treatment outcome, where such issues are not directly linked to their personal professional medical skills.

Finally, we tried to examine our data pool to assess the dichotomy between the "voice of medicine" versus "the voice of lifeworld", which was originally proposed by Mishler (1984). In fact, the observed general theme of our local data does not seem to support such a radical view for two reasons. First, we observed that a substantial amount of doctors' responses were in fact reciprocating to, and siding with the patients' appeal to "lifeworld" description, for example:

Extract 25- [Kassab-Bashi, R.: MAT: 2021]

1	Patient:	/ʃiltu gaweːni: mæːl tˤaħiːn/
		I lifted flour bags
2		/wχalleːtuːhæː bsajjæːrit()/
		And I put it in the (name's) car
3	Doctor:	/ʔuːuːuːuː/
		Ohhhhhh
4		/hæːðæː mæː maliːħ ʕaleːki/
		This is not good for you
5	Patient:	/ʔlgarm qalli: ʔntim ʔaħsan mininnæː/
		The garam said to me you are better than us
6	Doctor:	/dˤaɣabki ʔeːn/
		He hit you with an eye
7		/læːkn hæːðæː ʔdʒdʒhud mæː jrham maʕæːki/
		But this kind of effort is not suitable for you
8	Patient:	/maħħad jsæːʕd dktɔːr/
		There is no one with me to help doctor

Our explanation here is again sociocultural, where we think that such a linguistic strategy reflects a form of deeply-rooted local cultural norms, where the doctor is expected to share some form of common social grounds with the patient, besides showing empathy and concern about everyday life issues and frustrations.

Furthermore, our observation supports Atkinson's (1988:255) review of this same issue, where he maintains that such a dichotomy is actually an oversimplification of this notion of voices, where there are in fact multiple voices of medicine including for example the "voice of science" or "voice of experience", and that within uneventful occasions of doctor-patient encounters, such a drastic struggle for discursive supremacy is in fact quite rare. This could be shown in the following conversational excerpt:

Extract 26- [Kassab-Bashi, R.: MAT: 2021]

1	Doctor:	/wbldʒihteːn/
		And on both sides
2		/ʔllæː bdʒiha wħdi:(?)/
		Or in one side
3	Patient:	/bildʒihteːn jaʕniː jamiːn wjasæːɣ/
		On both sides I mean right and left
4	Doctor:	/ʔeː hæːj ʔarbitˁtˁlkæːħl/
		Yes these are the ligaments of the ankle
5		/zeːn kinsˁaːɣ ʕdkiː wadʒaʕ ʔasfal dˁahɣkiː(?)/
		Ok did you have lower back pain?
6	Patient	/ʔnæː marra dʒiːtu ʕaleːk kæːn ʕndiː ʔinzilæːq/
		Once I came to you [I had a prolapse]
7	Doctor:	/whassaʕ/
		[And now]
8	Patient:	/kæːn ʕndiː dˁaɣtˁ ʕalʕasˁab/
		I have pressure [on the nerve]
9	Doctor:	/ʔeː ʔeː/
		[Yes yes]
10	Patient:	/ʔlħamdilla hassa ʔaħsan/
		Thanks god I got well

11		/ʔlhamdilla χaffit/
		Thanks god it went over
12		/bas hassaʕ dˤahɣi: ʕabæːlak/
		And now as if [my back is
13	Doctor:	/dˤaʕiːf/
		[Weak]
14	Patient:	/whɔːni: ʕndiː/
		And now I have here
15	Doctor:	/ʔnsammiːhæː wisæːda taħtlɣkbiː/
		We call it a pillow under the knee

Here, one could notice that the patient herself was appealing to some form of "biomedical" voice, which was signified by such lexical choice as "pressure on the nerve", or "prolapse disk", which was, on the other hand, introduced within a smooth conversational interaction aiming to resolve her original "lifeworld" problem.

5. Conclusions

It is quite evident that although doctor-patient encounter in Mosuli Arabic follows the same overall conversational structure of the medical consultation in agreement with the general outlines of published western literature, yet it is in fact rich in various peculiar, and largely culture-specific, linguistic conversational strategies which were effectively utilized along the phases of the encounter. This was in agreement with our research hypothesis that there must be some linguistic effect of local Mosuli culture, on the conversational stream of the medical encounter.

Our empirical findings, concerning specific forms of unique lexical and syntactic selections, seem to support the aforementioned views of Stein (1990) that medicine is a cultural system in its own right, where many of its linguistic defining features are, at least in part, subconsciously shaped and utilized in accordance with acquired, deeply rooted local cultural resources. On a broader view, our work demonstrates that micro-analytical studies of language are quite valuable in understanding many of the hitherto unrecognized

aspects of medical discourse, where such linguistic approach of analysis could be rather helpful and rewarding in addressing crucial matters within the general field of healthcare system.

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السمات اللغوية المتشكلة ثقافيًا للحوار بين الطبيب والمريض باللغة العربيَّة الموصليَّة: دراسة تحليل لغوي حواري

راوية طارق قصاب باشي *

نشوان مصطفى الساعاتي**

المستخلص

على الرغم من أَنَّ السمات اللغوية الرئيسة المميزة للمقابلة الطبية تكون متقاربة نسبيًا في جميع أَنحاء العالم، إِلَّا أَنَّ هناك بعض السمات اللغوية الخاصة الَّتي تتأثر بالثقافة المحلية ضمن المجتمعات المختلفة، وبتحليل المحادثة، قمنا بدراسة محتويات الحوار الطبي في (75) مقابلة بين الطبيب والمريض، من أَجل تسليط الضوء على بعض السمات اللغوية الخاصة باللغة العربية الموصلية الَّتي تم التقصي عنها في المراحل المختلفة للاستشارة الطبية، من بدء الحوار إِلى نهايته، وتم التحري عن الاستراتيجيات الفريدة للمحادثة الَّتي تستخدم لتشكيل الإِجراءات الاجتماعيَّة اثناء اللقاء الطبي مثل التعبير عن التعاطف، استشعار الطبيب بوجود الأَمراض المختلفة لدى المرضى، وعملية تشكيل الترابط والتعاون بين الطبيب والمريض .

تبنَّت الدراسة هيرتيج (2004) أُنموذجًا للتقصي عن السمات الستة المحددة التي تمثل (مؤسسية) اللقاء بين الطبيب والمريض، لإيضاح فيما إِذا كان هناك أَنماط لغوية معينة للتواصل بين الطبيب والمريض في اللهجة الموصليَّة العربيَّة فرضية الدراسة، وإِنَّ لقاء الطبيب مع المريض يبدو أَنَّه نشاط اجتماعي منظم للغاية، ولكن يجب أَن يكون هناك بعض السمات المميزة للغة المحلية المستخدمة داخل المجتمع الموصلي العربي المحلي.

وأَظهرت النتائج التي توصَّلنا إِليها أَنَّ اللهجة الموصليَّة العربيَّة في الحقيقة غنية بالإمكانيات اللغوية المختلفة، بشكل اختيارات معجمية ونحوية على وجه الخصوص، الَّتي يمكن استخدامها بشكل مفيد اثناء التواصل بين الطبيب والمريض.

الكلمات المفتاحية: الحوار الطبي، تحليل لغوي، العربية الموصليَّة.

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